



## *Managed Care: A National Experiment. Unanswered Questions and Potential Risks*

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The rapid growth of managed-care organizations is transforming the health care system as managed-care plans penetrate market after market. For public and private purchasers of insurance, the question has increasingly become one of which plan to select, rather than whether or not to shift traditional health insurance coverage to managed care. The insured family may no longer have a choice, as employers switch to offering a single, managed-care plan and public purchasers turn increasingly to mandatory enrollment.

The nation is in the midst of an experiment of unprecedented proportions. With most of the growth in managed care coming from new organizational forms, the industry is moving away from its traditional base, on which past research studies rest, into largely uncharted waters. What we have “learned” from the past about the potential and promise of managed care is now open to question. During a recent case study site visit in southern California, one of those interviewed stressed that “evolution is the wrong word for what’s going on here. It’s happening too fast, it’s too dramatic. It’s a revolution.”

Access and quality are central concerns as the rapid, market-driven transformation continues. In a changing industry, there is a need to understand what works well, and under what circumstances. Salient questions must be asked if understanding is to be gained: How well will managed care perform as it enrolls sicker,

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vulnerable populations? What will be the consequences for the uninsured as managed care enrolls increasing numbers of the insured? What are the risks to access and quality for the insured as well as the uninsured? How can we monitor change? What minimum standards are essential to enhance or protect access and quality?

These large, unanswered questions are central to the Commonwealth Fund's efforts to sponsor a range of projects focused on managed care. This effort grows out of the Fund's program commitment to improve health, with particular emphases on vulnerable populations including the elderly, women, minorities, and low-income families. In the last few years, managed care has become a paramount concern in all these populations. The Fund's activities focus on what we can learn to further national efforts to improve health and the quality of life.

This presentation overviews current Commonwealth Fund managed-care project activities and discusses some preliminary findings. To provide a context for those activities, this paper first outlines recent trends and, based on the trends, raises questions and concerns about access and quality. The projects summarized in this paper highlight the pressing need for innovative research, monitoring and development of quality standards for the years ahead.

### ***Managed Care Trends: Basic Trends***

One legacy of recent failed efforts to enact universal coverage has been the intensification and acceleration of managed-care market growth in the 1990s. From a slow evolution, managed care is now growing at a revolutionary pace. If managed-care organizations are defined as including a broad array of organizational structures having the shared characteristic of restricting enrollees' choice to physicians and other medical services who agree to the rules, guidelines, and payment levels set forth by the plan for full coverage, managed care today enrolls the vast majority of the employed insured population working for medium and larger firms

and is growing rapidly among the Medicaid and Medicare population.\*\* Growth has been particularly rapid among newer forms of managed care.

Including all types of organizations licensed as health maintenance organizations, HMO enrollment reached 51 million by the end of 1994, nearly 20% of the population.<sup>1</sup> Enrollment grew by more than 5 million from 1993 to 1994, and is up from 37 million in 1990. In cities such as Los Angeles, San Francisco, Minneapolis, and Boston, HMOs now enroll over 50% of the insured population. Cities with a shorter history of HMOs, such as New York, have seen HMO penetration rates double in 1 to 2 years.

The pace of change has been particularly rapid among the employed population. Based on surveys of medium-size and larger employers (firms with 200 or more employees), managed-care enrollment has risen from 29% in either an HMO, PPO or POS plan in 1988, to 47% in 1991, to 65% in 1994.<sup>2</sup> At the same time, the share of traditional fee-for-service insurance plans without utilization review controls shrank from dominance to barely 6% of this employed population.

Medicaid managed-care enrollment, counting all types of plans, has grown by more than 60% in the past 2 years. By 1994, Medicaid managed-care enrollment accounted for nearly a quarter of the Medicaid population (23%) or 7.8 million people, up from 4.8 million enrolled (14%) in 1993.<sup>3</sup> New York and other states are considering whether to follow the lead of Tennessee, which, as of January 1, 1994, had enrolled its entire Medicaid population, including the disabled and chronically ill, into managed-care plans. In budget-driven Medicaid strategies, managed care is viewed as a potential solution to difficult payment and management decisions. By shifting responsibility from the public sector to private

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\*\* Managed-care organizations range from more tightly structured group- or staff-model health maintenance organizations (HMOs), to looser Independent Practice Association (IPA) or network HMOs to still looser networks called "preferred-provider organizations (PPOs)" that typically allow participants to go outside networks but with significantly increased cost-sharing and reduced payment levels. In contrast to PPOs, HMOs have typically required use of their plan networks except in an emergency. However, most recently HMOs have developed insurance add-ons (with deductibles and cost sharing) or "point-of-service" (POS) arrangements to provide partial coverage of non-network services.

plans, many states are hoping for quick cost savings and new controls in the future.

The senior citizen population covered by Medicare is now a major target for managed-care plans. As the "last frontier", Medicare offers a new, 37-million-person market for expansion. As of 1994, some 3 million Medicare beneficiaries (9% of those enrolled in the program) were in some form of managed-care arrangement, compared to 1 million in 1985.<sup>4</sup> Growth has accelerated into 1995.

### ***Managed-care Industry: Shift from Traditional Bases***

As managed care has flourished it has abandoned its historic foundation of nonprofit, local, and regional plans based on group- or staff-model HMOs. Group- and staff-model pioneers once dominated managed care, but their enrollment has stagnated during the 1990s despite the rapid growth in the industry. Among licensed HMOs, group/staff plan enrollment has dropped from a 76% share of the industry in 1981 to less than a third (31%) in 1994. IPA- and network-model HMOs, which use financial contracts and plan controls to build networks, have grown rapidly and today account for two-thirds of enrollment and most recent HMO growth.

At the same time, the industry has shifted from nonprofit to for-profit, publicly traded, investor-owned firms. As a result of sales, conversions, and the entry of new investor-owned companies, the nonprofit share of HMO enrollment dropped from 74% of the industry in 1985 to 42% by 1994.<sup>†</sup> Plans that began with 1974 HMO Act grants to nonprofit start-ups have rushed to convert and sell shares to investors to grow and buy into new markets. New fortunes have been created as a result of buying and selling plans. Most recently, Blue Cross and Blue Shield plans have been shedding their historical nonprofit status to join the trend.

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<sup>†</sup> According to enrollment by tax status. 1985 data are derived from an unpublished 1994 Commonwealth Fund report by Bradford Gray and Mark Schlesinger, based on Interstudy plan data; 1994 data are from Ref. 1.

A further shift has occurred in the geographic base of parent plans. Whereas plans initially formed around local physician and hospital networks, mergers and acquisitions have given rise to large national plans, smaller and more regional plans have been disappearing in mature markets. National plans, having more than 1 million members, are no longer uncommon. As of 1993, 11 national companies with 1 million or more members accounted for 50% of total HMO enrollment.\*

With the growth of new forms of managed care has come new methods of paying for care; these shift risk downward and give physicians financial incentives to provide less or less-expensive care. At the outset, the financial contracts used by IPA- and network-model HMOs and PPOs typically retained fee-for-service methods of paying for care, with negotiated discounts as the price for access to insured patients. While managed-care plans continue to use discounted fee-for-service as a major payment method and are demanding ever deeper discounts, capitation contracting is emerging as a major new trend. Capitation involves paying physicians and hospitals a fixed amount per person “enrolled” in the physician practice (or physician-hospital mini-network). Capitation shifts risks away from the plan to providers, and changes incentives from rewards for doing more to rewards for doing less.

### ***Uninsured and Under-insured Continue to Grow***

Despite economic recovery, census surveys in 1994 found some 40 million uninsured among the under-65 population. A major erosion of employment-based coverage has driven the rise in the uninsured: since 1988, the share of the under-65 population covered by employment-based plans has declined from 67% to 61%.<sup>5</sup> During the same period, Medicaid expanded to cover 9 million additional beneficiaries, an increase from 9% to 13% of the non-elderly population. This Medicaid expansion to children and low-

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\* Based on author's calculation of GHAA total enrollment numbers for national plans and plan merger data for 1993. This does not include recently announced mergers, such as the Harvard Community Health Plan-Pilgrim merger described elsewhere in this issue.

income pregnant women partially offset what might otherwise have been an even more rapid increase in the uninsured.

Newly published counts of the under-insured have revealed that an additional 29 million people have insurance inadequate to protect them in the event of serious illnesses.<sup>6</sup> Adding the uninsured and under insured together, nearly 70 million people, about a third of the population younger than 65, may be unable to pay for care despite federal and state efforts to expand Medicaid coverage. If recently proposed congressional changes in Medicaid are enacted, erosion of insurance coverage could accelerate dramatically.

With managed care thriving and tightening its hold on the well-insured population, negotiated discounts and stricter financial contracts will make it increasingly difficult to subsidize care for the uninsured. As a result, the un- and under-insured are likely to be at severe risk for new access barriers and diminished care. Understanding the risks and implications of managed care, absent universal coverage, is one of the central, critical public policy concerns for the years ahead.

### ***Promises and Concerns***

Public and private purchasers have turned to managed care for its promise of improved efficiency and effectiveness of care and reduced costs, while maintaining or enhancing quality of care. The hope is that a stronger emphasis on preventive and primary care, coverage of services in the home and beyond traditional acute medical care settings, and integration of services, will improve access and outcomes of care and reduce unnecessary use of expensive resources and duplication of services. In theory, managed care's emphasis on coordination holds out particular promise for improving care for the chronically ill and those in need of a complex of services from different sources.

Whether past evidence in support of this potential will obtain in the future is still an open question. To date, research studies of managed care have largely been based on studies of pioneer group- and staff-model HMOs such as Kaiser Permanente, Group

Health of Puget Sound, the Harvard Community Health Plan and HIP. Such plans have operated historically as tightly integrated organizations that bind physicians and other medical care staff together with a shared culture and philosophy as well as shared offices, clinics, and budgets. As managed care moves away from this base, it is not clear how newer models will perform.

Several trends raise significant concerns about the potential new access and quality risks.<sup>7</sup> Competitive incentives to avoid rather than manage risk, the growing numbers of uninsured, and enrollment of vulnerable populations at a time when our ability to measure, much less monitor, quality is still in its infancy, suggest that significant risks may undermine the theoretical potential of managed care.

Because plans compete on the basis of costs, unadjusted for risk, strong incentives to avoid risk exist. Currently, the plan that succeeds in attracting a healthier mix of enrollees will have a competitive advantage. Given the highly skewed nature of health care costs, opportunities abound for subtle and not-so-subtle risk selection. Studies of costs of care among varying population groups regularly find that the sickest 10% of any given group account for about 70% of total costs; the healthiest 90% account for only 30% of costs. Given the cost distribution, a plan that gains a reputation for serving a sicker population well may be at a competitive disadvantage: the reputation could attract a sicker patient mix, drive up total plan costs, and make the plan appear expensive when purchasers compare plans on the basis of average costs. Without adequate adjustment for risk, competition based on avoiding risk currently holds greater potential financial rewards than competition based on improved management of care.

As capitation becomes more widespread among providers, risk selection becomes a concern for physicians as well as for plans. Under fee-for-service, the sicker the insured population, the higher the physician's income. Capitation reverses the income equation by rewarding those who do less, not more.

New risk arrangements raise a critical concern for physicians' continued autonomy to act as their patients' agents and advocates.

Access to and quality of care rely heavily on physicians acting as professionals on behalf of their patients, with the freedom to make clinical decisions independent of personal interests or larger corporate concerns. Whether managed-care organizations will develop governance structures that preserve the physician's independence, voice, and advocacy remains to be seen. We know little about the extent to which current financial contracts and organizational controls potentially compromise clinical decisions or place physicians in situations of potential conflict of interests. We also know little about the rules of entry and exit that govern existing networks, and the ways these influence physicians or affect access and quality.

The uninsured are at particular risk as managed-care organizations negotiate to drive down subsidies for care. Academic health centers, other health centers, and clinics that have traditionally maintained a mission of providing care to all in need, regardless of ability to pay, or that have subsidized teaching, research, and other service missions from patient-care revenues, will be hard-pressed to support their missions. Rates are not likely to be competitive if payments from insured patients must subsidize care for the uninsured or services not well covered by insurance. If resources to support public and social services disappear, the critical infrastructure for community health systems will be at risk.

Despite Medicaid's rush to managed care, unanswered questions persist regarding how well managed care will perform as it serves a sicker, more vulnerable population. As managed care increases enrollment among the Medicare and Medicaid population, the mix of enrollees will shift away from plans' traditional base of the under-65, middle-income, employed population. The changing mix poses new challenges, given the health care needs and vulnerability of low-income, disabled, elderly, and chronically ill patients. We have little knowledge of the necessary adaptations, nor do we know whether or how managed-care plans will respond with the system changes necessary to serve populations who may not have phones, transportation, or spouses at home to provide

care in the event of early hospital discharge, or who may be homeless.

An overarching concern is our current inability to hold plans accountable by comparing, monitoring, and assessing access and quality. Currently, we lack a system for measuring or monitoring plans. We are just beginning to develop patient surveys and comparison measures; as yet there are few community-based requirements for monitoring or reporting the results of comparisons. To date, most of the impetus for quality standards has come from large, private-employer purchasers. Further development depends critically on these employers staying involved in plan purchase decisions and holding plans accountable for quality of care as well as costs. If employment-based coverage erodes further and insured markets move toward individual purchase of insurance, group pressure for quality measures may decline unless the public sector fills the void.

### ***Commonwealth Fund Managed-care Activities: Seeking Answers to Critical Questions***

The Commonwealth Fund and other foundations and public agencies are now seeking answers and supporting the development of improved methods of assessing and monitoring access and quality in an era of managed care. The Fund's current project efforts focus on three central goals: understanding the implications for the dual trends of declining coverage and expanding managed care; strengthening the ability to monitor quality of care from the patient's perspective; and understanding the implications for chronically ill and vulnerable populations. The projects seek to inform the public debate on emerging access and quality concerns resulting from trends in managed care, and to indicate actions necessary to continue progress toward improving health.

Patients' experiences in managed care offer one perspective on performance. In July 1995, the Fund released the first results of its study of the managed-care experience of employed workers and their families. Working with Louis Harris & Associates, we sur-

veyed 3,000 people in three cities to compare experience in fee-for-service and managed-care plans. The study investigated issues of plan choice and ratings of various dimensions of access and quality. A major finding of the study was the extent to which people change plans frequently (45% had changed within the past 3 years) and that most of the switching appears to be “involuntary” as a result of employers changing the plans offered to employees, or as a result of a change in jobs. Another major finding was the extent to which having a choice of plans affected plan ratings: a third of those enrolled in managed care without a choice of plan rated their plans “fair or poor”, compared to only 16% negative ratings for those who could choose their managed-care plans. The study also found that managed-care plans as a group scored lower than fee-for-service plans, even adjusting for choice, on various dimensions of access to care and ratings of physicians—including access to care in an emergency and for routine appointments. At the same time, use of preventive services and whether or not patients had a regular source of care were comparable. (As expected, fee-for-service received fewer excellent and more fair/poor ratings for out-of-pocket costs and coverage of preventive care services.)<sup>8</sup>

In partnership with the Kaiser Family Foundation, the Fund is currently supporting a series of case studies and surveys of low-income populations’ experience with managed care. Case studies and surveys in five states—New York, California, Minnesota, Oregon, and Tennessee—will compare the impact of managed care on the uninsured and the experience of those moving from traditional Medicaid programs to managed-care plans. Initial case studies of Tennessee and Oregon have been publicly released. Survey and additional case study results will be released in the fall/winter of 1995 and early 1996. The combination of case studies and surveys will help to monitor different approaches and draw implications for subsequent state and federal policy development.

Field work is nearly complete for a national Fund survey of physician experiences. The survey will over-sample minority physicians and those working in group and staff-model HMOs to

compare experiences with different types of managed care in different areas of the country. By design, the survey will have a spectrum of physicians, ranging from those with little involvement in managed care, to those participating in multiple plans, to those working exclusively or almost exclusively for a single managed-care organization. The study will compare practice satisfaction, experiences with delivering patient care and referrals, and administrative issues.

Several projects focus on academic health centers and the impact of managed care on the centers' missions. Case studies are investigating strategies and the implications of these strategies for the future. Tracking of financial health and resources devoted to teaching, research, and service (uninsured, Medicaid, specialized services) will look at changes over time in different competitive markets. Central questions include: To what extent are missions at risk? Do different strategies to survive offer the potential of preserving access for vulnerable populations? Two of the case studies scrutinize the impact of Medicaid conversion to managed care on academic health centers in Tennessee that have traditionally served high proportions of uninsured and Medicaid patients. Initial reports will be available from the Commonwealth Fund in fall, 1995.

Another study examines organizational structures and structural changes among network- and IPA-model HMOs and the impact on market performance. This project, led by Nancy Kane of Harvard University, tracks plan financial performance and uses case studies to understand structural differences. The study will draw largely from interviews and financial data to compare performance, inasmuch as field work has revealed a general lack of quality performance information. One central finding from initial working papers is that access to capital funds gained from conversion to for-profit status has been used mainly to purchase entry into new markets rather than for local investment. This finding supports a conclusion that expansion, rather than a need for capital for infrastructure, has been driving conversions to investor-owned status.

Finally, the Fund is sponsoring several projects to improve its ability to assess and compare quality. We are supporting the efforts of the National Committee on Quality Assurance as it seeks to develop new quality standards and reporting mechanisms to dispense information to the public, including individual families and purchasers. The dual effort to further comparison standards and to provide timely, comparative information is critical for future efforts to evaluate plan performance for all population groups. We are also supporting efforts to work with state Medicaid programs to improve their ability to monitor and track plan performance for low-income populations.

These activities are only a beginning and part of a shared effort of many foundations and public agencies to learn from and inform public decision-makers regarding the implications of the ongoing managed-care transformation. Rapid change affords a unique opportunity for learning from experience and providing insight into potential strengths and risks. Hopefully, through the Fund's focus on outcomes that affect patients, vulnerable populations, and community services, we will help provide a framework for future improvements. The years ahead are likely to test severely the nation's ability to provide access and a humane health care system. By providing a national information resource, foundations can help keep the long-term focus on the "bottom line" of improving health and the quality of life.

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